

# Provider Web Portal Quick Guide – Submitting a Claim with Other Insurance or Medicare Crossover Information

This Quick Guide covers when and how to enter other insurance information (Third-Party Liability) or Medicare crossover information.

Other insurance information should be entered on claims with Third-Party Liability (TPL)/commercial insurance. For claims billed to Medicare, provide the Medicare crossover information (see description below).

Medicare crossover information should be entered on any claim that was billed to Medicare first. The term “Crossover claim” may refer to a claim that is directly from Medicare (and has since “crossed over” to Health First Colorado [Colorado’s Medicaid Program] for processing) **or** a provider-initiated claim (submitted via the Provider Web Portal, batch or paper).” A crossover claim does not necessarily have to come directly from Medicare. Medicare Health Maintenance Organization (HMO) Co-pays should be treated like original Medicare Coinsurance. Enter the total of Medicare Coinsurance + Medicare Co-pay amount into the Co-insurance Amount field under the Medicare Crossover Details section of the claim.

From the list below, identify the example below which most closely matches your claim, then proceed to the appropriate page for instructions. The sample screens shown in this guide may vary depending on claim information.

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# Entering Other Insurance Information on a Claim

## Professional Claim with TPL

1. On the Submit Professional Claim: Step 1 page, complete all applicable fields, then check the "Include Other Insurance" box under the Claim Information section. Click "Continue." If you are submitting a claim with Medicare crossover information, see the instructions starting on page 13 of this guide.

**Submit Professional Claim: Step 1** ?

\* Indicates a required field.

Claim Type

**Provider Information**

Billing Provider ID	<input type="text"/>	ID Type	<input type="text"/>	Name	<input type="text"/>
Taxonomy	<input type="text"/>				
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>	Name	<input type="text"/>
Taxonomy	<input type="text"/>				
Supervising Provider ID	<input type="text"/>	ID Type	<input type="text"/>	Name	<input type="text"/>
Taxonomy	<input type="text"/>				
Service Facility Location ID	<input type="text"/>	ID Type	<input type="text"/>	Name	<input type="text"/>
Taxonomy	<input type="text"/>				

**Member Information**

*Member ID	<input type="text"/>	First Name	<input type="text"/>
Last Name	<input type="text"/>		
Birth Date	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>		
City	<input type="text"/>		
State	<input type="text"/>	Zip Code	<input type="text"/>

**Claim Information**

Date Type	<input type="text"/>	Date of Current	<input type="text"/>
Accident Related Reason	<input type="text"/>		
*Patient Number	<input type="text"/>		
*Transport Certification	<input type="radio"/> Yes <input type="radio"/> No		
Enter a Previous Claim ICN if filing a claim with dates of service older than 120 days. The previous claim must have been filed within the defined timely filing period.			
Previous Claim ICN	<input type="text"/>		
Note	<input type="text"/>		
*Does the provider have a signature on file? <input type="radio"/> Yes <input type="radio"/> No			
<b>Include Other Insurance</b> <input checked="" type="checkbox"/>		Total Charged Amount \$0.00	

**Continue** **Cancel**

## 2. On the Submit Professional Claim: Step 2 page under the Other Insurance Details section, click [+] to add new other insurance information.

**Submit Professional Claim: Step 2** ?

\* Indicates a required field.

**Claim Type** Professional

**Provider Information**

**Billing Provider ID** [REDACTED] **ID Type** NPI **Name** [REDACTED]

**Taxonomy** Clinic/Center - Primary Care

**Patient and Claim Information**

**Member ID** [REDACTED] **Gender** Female

**Member Birth Date** [REDACTED] **Total Charged Amount** \$0.00

[Expand All](#) | [Collapse All](#)

**Diagnosis Codes** -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.  
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1			

1 \***Diagnosis Type** ICD-10-CM \***Diagnosis Code** [REDACTED]

[Add](#) [Reset](#)

**Other Insurance Details** -

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

[Refresh Other Insurance](#)

#	Carrier	Policy ID	Action
+ Click to add a new other insurance.			

[Back to Step 1](#) [Continue](#) [Cancel](#)

**3. Enter the insurance company name in the Existing Carrier field, then select the appropriate carrier from the drop-down list. If the carrier is not found, select Other Carrier and type the Carrier Name.**

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

**Refresh Other Insurance**

#	Carrier	Policy ID	Action
---	---------	-----------	--------

Click to collapse.

Select an existing Carrier or specify an Other Carrier

☒ Existing Carrier

☐ Other Carrier

\*Policy Holder Last Name

\*Policy ID

\*Effective From

Insurance Type

\*Responsibility

KAISER

000461-KAISER PERMANENTE

002682-KAISER PERMANENTE

003682-KAISER-EXTENDED CHOICE PLAN

003712-KAISER HMO CALIF.

003877-KAISER

004124-KAISER/COLORADO SPRINGS

\*First Name

MI

Effective To

Relationship to Insured

\*Claim Filing Indicator

Add

Cancel

Back to Step 1

Continue

Cancel

#### 4. Enter the Policy Holder Last Name, First Name, Policy ID and Effective Dates (as applicable). Leave the Insurance Type field blank.

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

**Refresh Other Insurance**

#	Carrier	Policy ID	Action
<input type="checkbox"/> Click to collapse.			
<b>Select an existing Carrier or specify an Other Carrier</b>			
<input checked="" type="radio"/> <b>Existing Carrier</b> 000461-KAISER PERMANET			
<input type="radio"/> <b>Other Carrier</b>			
<b>*Policy Holder Last Name</b> SMITH <b>*First Name</b> JOHN <b>MI</b> J			
<b>*Policy ID</b> ABCDEF123456789			
<b>*Effective From</b> 01/01/2018 <b>Effective To</b>			
<b>Insurance Type</b>			
<b>*Responsibility</b> <b>*Patient Relationship to Insu</b>			

**Leave the  
Insurance Type  
field blank.**

## 5. Select the payer responsibility from the drop-down list.

**Note:** Health First Colorado is the payor of last resort.

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

[Refresh Other Insurance](#)

#	Carrier	Policy ID	Action
---	---------	-----------	--------

☐ Click to collapse.

Select an existing Carrier or specify an Other Carrier

☒ Existing Carrier

☐ Other Carrier

\*Policy Holder Last Name

\*First Name

MI

\*Policy ID

\*Effective From

Effective To

Insurance Type

\*Responsibility

\*Patient Relationship to Insured

\*Claim Filing Indicator

P-Primary

S-Secondary

T-Tertiary

U-Unknown

A-Payer Responsibility Four

B-Payer Responsibility Five

C-Payer Responsibility Six

D-Payer Responsibility Seven

E-Payer Responsibility Eight

F-Payer Responsibility Nine

G-Payer Responsibility Ten

H-Payer Responsibility Eleven

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Privacy Notice

05.00.20

## 6. Select the relationship of the covered individual to the responsible individual from the drop-down list.

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

**Refresh Other Insurance**

#	Carrier	Policy ID	Action
---	---------	-----------	--------

☐ Click to collapse.

**Select an existing Carrier or specify an Other Carrier**

☒ Existing Carrier

☐ Other Carrier

**\*Policy Holder Last Name**

**\*First Name**  **MI**

**\*Policy ID**

**\*Effective From**

**Effective To**

**Insurance Type**

**\*Responsibility**

**\*Patient Relationship to Insured**

**\*Claim Filing Indicator**

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- 01-Spouse
- 18-Self
- 19-Child
- 20-Employee
- 21-Unknown
- 39-Organ Donor
- 40-Cadaver Donor
- 53-Life Partner
- G8-Other Relationship



## 7. Select the Claim Filing Indicator from the drop-down list, then click the "Add" button.

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

**Select an existing Carrier**

☐ Existing Carrier

☐ Other Carrier

**\*Policy Holder Last Name**

**\*Policy ID**

**\*Effective From**

**Insurance Type**

**\*Responsibility**

**\*Claim Filing Indicator**

11-Other Non-Federal Programs  
12-Preferred Provider Organization (PPO)  
13-Point of Service (POS)  
14-Exclusive Provider Organization (EPO)  
15-Indemnity Insurance  
17-Dental Maintenance Organization  
AM-Automobile Medical  
BL-Blue Cross/Blue Shield  
CH-Champus  
CI-Commercial Insurance Co.  
DS-Disability  
FI-Federal Employees Program  
HM-Health Maintenance Organization  
LM-Liability Medical  
OF-Other Federal Program  
TV-Title V  
VA-Veterans Affairs Plan  
WC-Worker's Compensation Health Claim  
ZZ-Mutually Defined

**Refresh Other Insurance**

**Policy ID**

**Action**

JOHN MI

01-Spouse

**Add** **Cancel**

**Back to Step 1** **Continue** **Cancel**

## 8. Review the next screen to ensure the other insurance information has been saved. If you are finished adding other insurance information, click "Continue." If you need to add more other insurance information, click + and repeat the applicable steps.

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

**Refresh Other Insurance**

#	Carrier	Policy ID	Action
1	000461-KAISER PERMANENTE	ABCDEF123456789	<a href="#">Remove</a>

☐ Click to add a new other insurance.

**Back to Step 1** **Continue** **Cancel**



**9. Proceed to the Submit Professional Claim: Step 3 page and complete all applicable fields. Click "Add," then repeat the process until all service detail lines have been added.**

**Whether the TPL was paid or denied, you must enter a paid date.**

### TPL Denied

**If the TPL was denied, enter "0.00" in the Paid Amount field and "1" in the Paid Units field.**

**Once complete, click "Submit."**

**Submit Professional Claim: Step 3**

\* Indicates a required field.

**Claim Type:** Professional

**Provider Information**

Billing Provider ID [Redacted] ID Type NPI Name [Redacted]

Taxonomy Clinic/Center - Primary Care

**Patient and Claim Information**

Member ID [Redacted] Gender Female

Member Birth Date [Redacted] Total Charged Amount \$0.00

[Expand All](#) | [Collapse All](#)

**Diagnosis Codes**

**Other Insurance Details**

#	Carrier	Policy ID
1	000749-HUMANA HEALTH CARE	5325234

**Service Details**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1							

**NDCs for Svc. # 1**

Click the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Carrier	Paid Amount	Paid Date	Paid Units	Action
1					

☐ Click to collapse.

Other Carrier [Redacted]

\*Paid Amount [Redacted] \*Paid Date [Redacted] \*Paid Units [Redacted]

[Add](#) [Cancel](#)

**If the TPL was denied, enter "0.00" in the Paid Amount field.**

**If the TPL was denied, enter the denial date in the Paid Date field.**

**If the TPL was denied, enter "1" in the Paid Units field.**

**Check the “Include Other Insurance” box under the Claim Information section, then click “Continue.”**

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**2. On the Submit Institutional Claim: Step 2 page under the Other Insurance Details section, enter the insurance company name in the Existing Carrier field, then select the appropriate carrier from the drop-down list. If the carrier is not found, select Other Carrier and type the Carrier Name.**

Submit Institutional Claim: Step 2

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

Refresh Other Insurance

#	Carrier	Policy ID	Paid Amount	Paid Date	Action
<input type="checkbox"/> Click to collapse.					
<div> Select an existing Carrier or specify an Other Carrier </div> <div> <input checked="" type="radio"/> Existing Carrier <input type="text"/> </div> <div> <input type="radio"/> Other Carrier <input type="text"/> </div>					

**3. Enter the Policy Holder Last Name, First Name, Policy ID and Effective Dates.**

**Other Insurance Details**

Enter the carrier and policy holder information below.

Select a carrier from the Existing Carrier field. If the carrier is not found, select the Other Carrier radio button and enter an Other Carrier.

Refresh Other Insurance

#	Carrier	Policy ID	Paid Amount	Paid Date	Action
<input type="checkbox"/> Click to collapse.					
<div> Select an existing Carrier or specify an Other Carrier </div> <div> <input checked="" type="radio"/> Existing Carrier <input type="text"/> </div> <div> <input type="radio"/> Other Carrier <input type="text"/> </div>					
<div> <div> *Policy Holder Last Name <input type="text"/> </div> <div> *Policy ID <input type="text"/> </div> <div> *Effective From <input type="text"/> </div> </div> <div> <div> *First Name <input type="text"/> </div> <div> Effective To <input type="text"/> </div> <div> MI <input type="text"/> </div> </div>					

**4. Proceed to the Submit Institutional Claim: Step 3 page and complete all applicable fields. Click "Add," then repeat the process until all service detail lines have been added. Once complete, click "Submit."**

Submit Institutional Claim: Step 3							
Service Details							
Select the row number to edit the row. Click the <b>Remove</b> link to remove the entire row.							
Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1							
1	<b>*Revenue Code</b> <input type="text"/>	<b>HCPCS/Proc Code</b> <input type="text"/>					
	<b>Modifiers</b> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
	<b>From Date</b> <input type="text"/>	<b>To Date</b> <input type="text"/>	<b>*Units</b> <input type="text"/>	<b>*Unit Type</b> <input type="text"/>			
	<b>*Charge Amount</b> <input type="text"/>						
<div><div>Add</div><div>Reset</div></div>							
Attachments							
Click the <b>Remove</b> link to remove the entire row.							
#	Transmission Method	File	Control #	Attachment Type	Action		
Click to add attachment.							
<div>Back to Step 1</div>				<div>Back to Step 2</div>			
				<div><div>Submit</div><div>Cancel</div></div>			

## Entering Medicare Crossover Information on a Claim

### Professional Claim with Medicare (Crossover)

1. On the Submit Professional Claim: Step 1 page, complete all applicable fields under the Provider Information, Member Information and Claim Information sections. Do **not** check the "Include Other Insurance" box under the Claim Information section. Click "Continue."

**Submit Professional Claim: Step 1**

**Provider Information**

Billing Provider ID  ID Type  Name   
Taxonomy

Referring Provider ID  ID Type  Name   
Taxonomy

Supervising Provider ID  ID Type  Name   
Taxonomy

Service Facility Location ID  ID Type  Name   
Taxonomy

**Member Information**

\*Member ID

Last Name  First Name   
Birth Date

Address

City   
State  Zip Code

**Claim Information**

Date Type  Date of Current

Accident Related Reason

\*Patient Number

\*Transport Certification ☐ Yes ☐ No

Enter a Previous Claim ICN if filing a claim with dates of service older than 120 days. The previous claim must have been filed within the defined timely filing period.

Previous Claim ICN

Note


\*Does the provider have a signature on file? ☐ Yes ☐ No

Include Other Insurance ☐ Total Charged Amount \$0.00

**Do not check the "Include Other Insurance" box.**

**Continue** **Cancel**

**2. On the Submit Professional Claim: Step 2 page, complete all applicable fields under the Diagnosis Codes section, then click "Add." Repeat until all diagnosis codes have been added, then click "Continue."**

Submit Professional Claim: Step 2			
Diagnosis Codes			
Select the row number to edit the row. Click the <b>Remove</b> link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.			
#	Diagnosis Type	Diagnosis Code	Action
<u>1</u>			
1	*Diagnosis Type ICD-10-CM ▼	*Diagnosis Code 	
<div><div>Add</div><div>Reset</div></div>			
Back to Step 1		Continue	Cancel



- 3. On the Submit Professional Claim: Step 3 page under the Medicare Crossover Details section, enter the associated Medicare crossover information for each service line. Click "Add" to repeat the process until all service detail lines have been added. Once complete, click "Submit."**

**Submit Professional Claim: Step 3**

**Service Details**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1							

1 **\*From Date**  **To Date**  **\*Place of Service**  **EMG**

**\*Procedure Code**  **Modifiers**    **\*Diagnosis Pointers**

**\*Charge Amount**  **\*Units**  **\*Unit Type**  **EPSTD Service** ☐ **Family Plan Service** ☐

**CLIA Number**

**Rendering Provider ID**  **ID Type**

**Taxonomy**

**Referring Provider ID**  **ID Type**

**Taxonomy**

**Medicare Crossover Details**

**Allowed Medicare Amount**  **Co-insurance Amount**

**Deductible Amount**  **Psychiatric Services Amount**

**Medicare Payment Amount**  **\*Medicare Payment Date**

**Add** **Reset**

**Attachments**

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

**Back to Step 1** **Back to Step 2** **Submit** **Cancel**

Medicare HMO Copays should be treated like original Medicare Coinsurance. Enter the total of Medicare Coinsurance + Medicare Copay amount in the "Co-insurance Amount" field.

## Institutional Inpatient Claim with Medicare (Crossover)

1. On the **Submit Institutional Claim: Step 1** page, complete all applicable fields under the **Provider Information** and **Member Information** sections.

**Submit Institutional Claim: Step 1** ?

**Provider Information**

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

<b>Billing Provider ID</b>	<input type="text"/>		<b>ID Type</b>	<input type="text"/>	<b>Name</b>	<input type="text"/>
<b>Taxonomy</b>	<input type="text"/>					
<b>Institutional Provider ID</b>	<input type="text"/>		<b>ID Type</b>	<input type="text"/>	<b>Name</b>	<input type="text"/>
<b>Taxonomy</b>	<input type="text"/>					
<b>Attending Provider ID</b>	<input type="text"/>		<b>ID Type</b>	<input type="text"/>	<b>Name</b>	<input type="text"/>
<b>Taxonomy</b>	<input type="text"/>					
<b>Operating Provider ID</b>	<input type="text"/>		<b>ID Type</b>	<input type="text"/>	<b>Name</b>	<input type="text"/>
<b>Taxonomy</b>	<input type="text"/>					
<b>Other Operating Provider ID</b>	<input type="text"/>		<b>ID Type</b>	<input type="text"/>	<b>Name</b>	<input type="text"/>
<b>Taxonomy</b>	<input type="text"/>					

**Member Information**

<b>*Member ID</b>	<input type="text"/>	
<b>Last Name</b>	<input type="text"/>	<b>First Name</b> <input type="text"/>
<b>Birth Date</b>	<input type="text"/>	
<b>Address</b>	<input type="text"/>	
	<input type="text"/>	
<b>City</b>	<input type="text"/>	
<b>State</b>	<input type="text"/>	<b>Zip Code</b> <input type="text"/>

- 2. Proceed to the Claim Information section and complete all applicable fields. Select the appropriate Facility Type Code from the drop-down list. Do not check the "Include Other Insurance" box under the Claim Information section.**

**Claim Information**

\*Covered Dates: [ ] - [ ]

\*Admission Date/Hour: [ ] (hh:mm) Dis: [ ]

\*Admission Type: [ ]

\*Admission Source: [ ]

\*Admitting Diagnosis Type: ICD-10-CM

\*Admitting Diagnosis: [ ]

\*Facility Type Code: [ ]

\*Patient Status: [ ]

\*Patient Number: [ ]

Enter a Previous Claim ICN if filing a claim with dates of service older than 120 days. The previous claim must have been filed within the defined timely filing period.

Previous Claim ICN: [ ]

Note: [ ]

Include Other Insurance: ☐

Total Charged Amount: \$0.00

**Facility Type Code Options:**

- 11-Hospital Inpatient (Part A)
- 18-Hospital Swing Bed
- 21-SNF Inpatient
- 28-SNF Swing Bed
- 41-Religious Nonmedical Health Care Institutions - Inpatient
- 65-Intermediate Care - Level I
- 66-Intermediate Care - Level II
- 86-Residential Facility

- 3. Proceed to the Medicare Crossover Details section and complete all applicable fields, then click Continue."**

**Medicare Crossover Details**

Deductible Amount: 0.00

Blood Deductible Amount: 0.00

Medicare Payment Amount: 0.00

Co-insurance Amount: 0.00

\*Medicare Payment Date: [ ]

**Continue** **Cancel**



## Institutional Outpatient Claim with Medicare (example for Part B-only)

1. On the Submit Institutional Claim: Step 1 page, complete all applicable fields. Do **not** check the "Include Other Insurance" box under the Claim Information section. Once complete, click "Continue."

When billing Medicare Part B-only (for inpatient services on an outpatient claim), choose facility type 12 from the drop-down list.

12-Outpatient  
13-Hospital Outpatient  
14-Hospital Other Part B  
22-SNF Inpatient Part B  
23-SNF Outpatient  
32-Home Health  
34-Home Health (Part B Only)  
43-Religious Nonmedical Health Care Institutions - Outpatient  
71-Clinical Rural Health  
72-Clinic ESRD  
73-Federally Qualified Health Centers  
74-Clinic OPT  
75-Clinic CORF  
76-Community Mental Health Centers  
77-Clinic - FQHC  
78-Licensed Freestanding Emergency Medical Facility  
79-Clinic - Other  
81-Nonhospital based hospice  
82-Hospital based hospice

### Submit Institutional Claim: Step 1

#### Claim Information

\*Covered Dates 04/23/2018 - \*04/25/2018

Admission Date/Hour 04/23/2018 - Discharge Hour (hh:mm)

Admission Type 3-Elective

Admission Source 1

Admitting Diagnosis Type ICD-10-CM

Admitting Diagnosis

Patient Status

\*Facility Type Code 13-Hospital Outpatient

\*Patient Number test1234

Previous Claim ICN

Note

Include Other Insurance ☐

Total Charged Amount \$0.00

Do **not** check the "Include Other Insurance" box.

Continue

Cancel

**2. On the Submit Institutional Claim: Step 2 page, complete all applicable fields, then click "Add." Repeat the process as needed for each detail line. Once complete, click "Continue."**

Submit Institutional Claim: Step 2				
<b>Diagnosis Codes</b>				
Select the row number to edit the row. Click the <b>Remove</b> link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.				
#	Diagnosis Type	Diagnosis Code	Action	
1				
1	*Diagnosis Type ICD-10-CM	*Diagnosis Code		
<div> <div>Add</div> <div>Reset</div> </div>				
<b>External Cause of Injury Diagnosis Codes</b>				
Select the row number to edit the row. Click the <b>Remove</b> link to remove the entire row.				
#	Diagnosis Type	External Cause of Injury Diagnosis Code	Action	
1				
1	*Diagnosis Type ICD-10-CM	*External Cause of Injury Diagnosis Code		
<div> <div>Add</div> <div>Reset</div> </div>				
<b>Patient Reason for Visit Diagnosis Codes</b>				
Select the row number to edit the row. Click the <b>Remove</b> link to remove the entire row.				
#	Diagnosis Type	Patient Reason for Visit Diagnosis Code	Action	
1				
1	*Diagnosis Type ICD-10-CM	*Patient Reason for Visit Diagnosis Code		
<div> <div>Add</div> <div>Reset</div> </div>				
<b>Condition Codes</b>				
Click the <b>Remove</b> link to remove the entire row.				
#	Condition Code	Action		
1				
1	*Condition Code			
<div> <div>Add</div> <div>Reset</div> </div>				
<b>Occurrence Codes</b>				
Select the row number to edit the row. Click the <b>Remove</b> link to remove the entire row. For an Occurrence Code enter the same From and To Date. For an Occurrence Span enter the From and To dates of the span.				
#	Occurrence Code	From Date	To Date	Action
1				
1	*Occurrence Code	*From Date	*To Date	
<div> <div>Add</div> <div>Reset</div> </div>				
<b>Value Codes</b>				
Select the row number to edit the row. Click the <b>Remove</b> link to remove the entire row.				
#	Value Code	Amount	Action	
1				
1	*Value Code	*Amount		
<div> <div>Add</div> <div>Reset</div> </div>				
<b>Surgical Procedures</b>				
Operating Provider is required to be entered back on Step 1 to allow for entry of surgical procedure codes within this panel.				
<a href="#">Back to Step 1</a>		<div> <div>Continue</div> <div>Cancel</div> </div>		

- 3. On the Submit Institutional Claim: Step 3 page, complete all applicable fields under the Service Details section. Enter the associated Medicare Crossover Details for each service line. Click "Add" to repeat the process until all service detail lines have been added. Click "Submit" once completed.**

Submit Institutional Claim: Step 3

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1							

1

\*Revenue Code

HCPCS/Proc Code

Modifiers

From Date

To Date

\*Units

\*Unit Type

Unit

\*Charge Amount

Medicare Crossover Details

Deductible Amount

0.00

Co-insurance Amount

0.00

Blood Deductible Amount

0.00

\*Medicare Payment Date

Medicare Payment Amount

0.00

NDCs for Svc. # 1

Add

Reset

Medicare HMO Copays should be treated like original Medicare Coinsurance. Enter the total of Medicare Coinsurance + Medicare Copay amount in the "Co-insurance Amount" field.



## Need More Help?

Please visit the [Quick Guides and Webinars](#) web page to find all the Provider Web Portal Quick Guides:

### **Aid Code and Benefit Plan Acronyms**

### **Are You Billing from the Correct Account?**

### **Copy, Adjust, or Void a Claim**

### **Delegates**

### **Delegate Access Definitions**

### **Entering NDC Information on a Claim**

### **Entering Third-Party Liability**

### **Provider Maintenance**

### **Provider Maintenance – License Update**

### **Pulling your 835 - Linking to your own TPID**

### **Pulling Your Remittance Advice (RA)**

### **Reading Your Remittance Advice (RA)**

- Internal Control Number (ICN) Information Sheet
- Region Code Information Sheet

### **Submitting a Claim with Other Insurance or Medicare Crossover Information**

### **Updating Additional TPL Information**

### **Updating your EFT**

### **Updating your ERA**

### **Verifying Member Eligibility and Co-Pay**

### **Viewing Prior Authorizations in the Portal**

### **Web Portal Registration**

## Provider Web Portal – Frequently Asked Questions (FAQs)

Please visit the [Provider FAQ Central](#) web page and look under the Billing and Web Portal headings to see Provider Web Portal FAQs.

## Provider Web Portal – Recorded Webinars

Click the links below to access the recorded webinars:

- [Session #1](#) Access the new Portal, Portal Registration, Log in, My Profile, Manage Accounts (including delegates)
- [Session #2](#) Provider Maintenance (including updates and affiliations), EFT/ERA Enrollment, Disenrollment
- [Session #3](#) Member Information and Eligibility Verification
- [Session #4](#) Remittance Advice (RA), Search Payment History, Search for Accounts Receivable Records, Make a Payment
- [Session #5](#) Notify Me, Alerts, Secure Correspondence
- [Session #6](#) Files Exchange, Resources
- [Session #7](#) Search & Submit CMS 1500, UB-04, Emergency Dental Claims, Prior Authorizations (Nursing Facility PETI PARs only)
- [Bridge](#) Bridge training for Community Centered Boards (CCBs) only